Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

September 15, 2014

The Honorable Sylvia Burwell
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

I am writing to express our serious concerns regarding the untenable situation that is the backlog of Medicare appeals. The backlog of appeals at the Administrative Law Judge (ALJ) level is unacceptable and the lack of due process that comes with the moratorium of assigning new cases is undemocratic and undermines the credibility of the Medicare program.

As you may be aware, the Committee has taken great interest in these issues, including holding a bipartisan briefing during which members heard from Department of Health and Human Services (HHS) officials about the Department's plans for addressing the problems. Though HHS officials referenced an appeals "settlement" process during the meeting, we were shocked to learn about the disclosure of the settlement policy[1] in the press. Even the *New York Times* referred to the audacious rollout of this policy involving billions of Medicare dollars as "quietly posted on the agency's website late Friday afternoon before the holiday weekend." Our staff has inquired about the development and authority for a settlement process on several occasions and did not receive satisfactory responses.

I question whether HHS has statutory authority for this settlement process. HHS states that the Federal Claims Collection Act, as amended (31 USC 3711), provides the statutory authority to settle hospital appeal of claims for inpatient services that Centers for Medicare and Medicaid Services (CMS) contractors have determined should have been billed and paid as hospital outpatient services. It is unclear how the HHS-referenced statute and its accompanying regulatory citation (42 CFR 405.376) provide the necessary authority as they pertain specifically to overpayments while the hospital's appeals pertain to a determination of a lack of medical necessity and, thus, non coverage. I ask for an explicit description of the HHS statutory authority to settle claims determined to be not medically necessary.

[1] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalParticipantSettlementInstructions.pdf.

Beyond the serious question of potentially operating outside of its authority, I also have several concerns with the process CMS has developed for the settlement of hospital claims. Why has CMS offered an "all or nothing" settlement approach? Each discharge is unique and the circumstances that apply pertaining to medical necessity in one case do not necessarily transfer to all cases. It seems that the "all or nothing" nature of this approach is based on what would be easiest to implement, however that does not protect the due process rights of Medicare providers and may lead to improper precedent. Further, CMS has not provided an empirical analysis to justify offering a settlement rate of 68 percent. How can the Committee ensure that this settlement is in the best interest of the limited resources available in the hospital insurance Trust Fund? How can hospitals be sure this rate is reflective of current reimbursement standards in either of CMS' inpatient or outpatient prospective payment systems?

I would like to call your attention to a recent analysis[2] that was made public by the Medicare Payment Advisory Commission (MedPAC). MedPAC reviewed specific hospital cases and compared the average inpatient reimbursement to the average outpatient reimbursement for similar services. Table 1 illustrates a selection of medical services from MedPAC's analysis.

Table 1: Medicare Data Illustrating the Difference in Inpatient versus Outpatient Reimbursement

Inpatient/Outpatient Services	Outpatient Payment as a share of inpatient payment
Chest pain	45%
Cardiac arrhythmia	39%
Digestive disorders	31%
Syncope & collapse	34%
Disorders of nutrition	30%

One might reasonably conclude that the settlement rate should be approximately 36% or the average of data included in Table 1. Yet, the rate CMS has offered for the settlement is nearly double what this data suggests it could be. This may represent an oversimplification of the data and perhaps there should be one rate for surgical cases and a different rate for medical cases. The point is, we just don't know because HHS and CMS have not released any data on what is actually in the backlog at the ALJ level. I urge you to make all data analysis CMS used to derive the 68 percent settlement rate publicly available, immediately.

I am also very concerned about how this settlement process will interact with the cost-sharing obligations that beneficiaries are responsible for. The same MedPAC analysis[3] also concluded that a beneficiary's liability for an inpatient stay is approximately $1,156 as compared to $282 for an outpatient stay. This staggering statistic suggests that beneficiaries are paying nearly 75 percent more out-of-pocket for short stays. Where is the settlement process for beneficiaries? What does HHS plan to do to address beneficiaries overpaying for short stays if hospitals pursue this settlement process?

---

[2] http://www.medpac.gov/documents/september-2014-meeting-presentation-hospital-short-stay-policy-issues.pdf?sfvrsn=0

[3] Ibid.

I am dismayed by HHS' reluctance to work with our Committee on establishing a fair and equitable settlement process that is legally permissible within the full extent of the law. This lack of engagement makes it challenging for the Congress to solve the current appeals problems and prevent similar problems in the future. If HHS delays or withholds information from the Congress, it should at least promptly resolve problems in a manner that is fair and transparent to beneficiaries and providers—HHS has failed to do so with this ill-thought settlement process.

Given the serious concerns we have outlined in this letter, I urge you to retract the settlement process CMS posted on its website on Friday, August 29. Instead, I urge you to work with me to establish a fair, transparent and conclusive settlement process that upholds the best interest of beneficiaries, providers and taxpayers.

Sincerely,

KEVIN BRADY
Chairman